Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

HOSPICE

Billing Instructions

(Chapter 388-551 WAC)

May 1999

About this publication

This publication supersedes all previous MAA Hospice Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
May 1999

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

HOW DO I BECOME A DSHS PROVIDER?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H	**(360) 664-0300**
I-O	**(360) 753-4712**
P-Z	**(360) 753-4711**

WHERE DO I SEND HARDCOPY CLAIMS?

Division of Program Support
PO Box 9245
Olympia WA 98507-9245

WHO DO I CONTACT IF I HAVE HOSPICE POLICY QUESTIONS?

If you have questions regarding **hospice policies**, or need **information on notification requirements,** write to:

Hospice Coordinator
Division of Health Services Quality Support
Medical Assistance Administration
PO Box 45506
Olympia WA 98504-5506

or call/fax:

(800) 545-5392
(360) 586-5299 FAX

WHERE DO I CALL IF I HAVE QUESTIONS REGARDING…?

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic Billing?

(360) 753-0318

or write to:

Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

HOW DO I REQUEST BILLING INSTRUCTIONS?

Check out our website:

http://maa.dshs.wa.gov

or write/call:

Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800)-562-6188

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Definitions

This section defines terms and acronyms used in these billing instructions.

Bereavement Counseling – Counseling services provided to a client's family or significant others following the client's death.

Brief Period – Six days or less. (WAC 388-551-1010)

Categorically Needy Program (CNP) – A program providing maximum benefits to persons whom qualify for Medical Assistance. These medical programs are funded with federal-state matched Medicaid (or Title XIX) dollars. They are on the Categorically Needy Program because their needs fall into certain program categories created by federal or state law. The Medical Assistance Identification card will show CNP in the program and scope of care area.

Certification Statement – A document that states the client's eligibility for each election period and is:

- Created and filed by the Hospice Agency for each MAA hospice client; and
- Signed by the physician or hospice medical director.

Children's Health Program – A statefunded medical program for children under age eighteen:

- Whose family income does not exceed one hundred percent of the federal poverty level; and
- Who are not otherwise eligible under Title XIX of the Social Security Act.

(WAC 388-500-0005)

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Continuous Care – Acute episodic care received by the client at their place of residence, with no restriction on length or frequency of visits, dependent on the client's needs.

Counseling – Services for the purpose of helping an individual and those caring for them to adjust to the individual's approaching death. Other counseling (including dietary counseling) may be provided for the purpose of educating or training the client's family members or other caregivers on issues related to the care and needs of the client.

Department or DSHS – The Washington State Department of Social and Health Services. (WAC 388-500-0005)

Discharge – Agency ends hospice care for a client.

Election Period – The time, 90 or 60 days, that the client is certified as eligible for and chooses to receive hospice care. (WAC 388-551-1010)

Election Statement – A written document provided by the hospice agency that is signed by the client in order to initiate hospice services.

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers that display transaction information regarding Medicare claims processing and payments.

Family – Any person(s) important to the client, as defined by the client. (WAC 388-551-1010)

General Assistance – Expedited Medicaid Disability (GA-X) – The GA-X program provides state-funded cash benefits to persons who have a disability decision pending with SSA. Eligible persons receive **CNP** medical coverage parallel to that provided to SSI recipients. This is full scope medical coverage.

Home and Community Services (HCS) Offices – An office of the department that is responsible for determining eligibility for individuals receiving or applying for longterm care services administered by Aging and Adult Services Administration at the community level.

Home Health Aide – An individual who provides personal care services and performs household services to maintain a safe and sanitary environment in areas of the home used by the client.

Homemaker – An individual who provides assistance in personal care, maintenance of a safe and healthy environment, and services to enable a client's plan of care to be carried out.

Hospice Agency – A licensed private or public agency that provides hospice care directly to terminally ill persons in places of temporary or permanent residence. This agency uses an interdisciplinary team composed of at least nursing, social worker, physician, and counseling services as directed by the hospice plan of care.

Hospice Interdisciplinary Team – The following health professionals who plan and deliver hospice care to a client as appropriate under the direction of a certified physician: home health aides monitored by a registered nurse, therapists (physical, occupational, speech-language), registered nurses, physicians, social workers, counselors, volunteers and others as necessary. (WAC 388-551-1010)

Institution – An establishment that furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally-retarded. (WAC 388-500-0005)

Intermittent – Stopping and starting again at intervals; pausing from time to time; periodic.

Limited Casualty Program – Medically Indigent (LCP-MNP) – This program is funded by federal/state dollars and offers a limited scope of medical care. A Medical Assistance Identification (MAID) card is issued with an **LCP-MNP** identifier when medical bills meet the client's spend-down amount.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With, or assigned to, a primary care provider;
- With, or assigned to, a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care

(WAC 388-538-001).

Maximum Allowable – The maximum dollar amount MAA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy as program defined in WAC 388-503-0310 and 388-503-1105; or
- Medically needy program as defined in WAC 388-503-0320.

(WAC 388-500-0005)

Medical Assistance Administration (MAA) – The administration within the department of social and health services authorized to administer the acute care portion of the *Title XIX* Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medically Necessary – A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section "course of treatment" may include mere observation or, where appropriate, no treatment at all.
(WAC 388-500-0005)

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

a) "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
b) "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

(WAC 388-500-0005)

Palliative – Medical treatment designed to reduce pain or increase comfort, rather than cure. (WAC 388-551-1010)

Patient Identification Code (PIC) – An alphanumeric code that is assigned by MAA to each client consisting of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Plan of Care – Description of hospice medical services for a client signed by their physician.

Program Support, Division of (DPS) – The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service – An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Residence – Where the client lives for an extended period of time.
(WAC 388-551-1010)

Remittance and Status Report – A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Respite Care – Short-term inpatient care provided to clients, only when necessary, to offer relief to the family members or other persons who have been caring for the client at home.

Revoke and Revocation – A client or family member's choice to stop receiving hospice care. (WAC 388-551-1010)

Routine Care – Intermittent care received by the client at their place of residence, with no restriction on length or frequency of visits, dependent on the client's needs.

Terminally Ill – The client has a life expectancy of six months or less, assuming the client's disease process runs its natural course. (WAC 388-551-1010)

Third Party – Any entity that is, or may be, liable to pay all or part of the medical cost of care of a medical program client. (WAC 388-500-0005)

Title XIX – The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

24-hour day – A day beginning and ending at midnight. (WAC 388-551-1010)

Usual and Customary Fee – The fee that the provider usually charges his or her non-Medicaid customers for a service or item. This is the maximum amount that the provider may bill MAA for the same service or item.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

About the Program

What is the Hospice Program? (WAC 388-551-1000)

Hospice is a 24-hour program coordinated by a hospice interdisciplinary team. The hospice program allows the terminally ill client to choose physical, pastoral/spiritual, and psychosocial comfort rather than cure. Hospitalization is used only for acute symptom management.

Hospice care is initiated by the choice of the client, family, or physician. The client's physician must certify a client as appropriate for hospice care.

Hospice care may be in a client's temporary or permanent place of residence.

Hospice care is ended by the client or family (revocation), the hospice agency (discharge), or death.

Bereavement care is provided to the family of the client who chooses hospice care. It provides emotional and spiritual comfort associated with the death of a hospice client.

How does a hospice agency become a MAA provider? (WAC 388-551-1300)

To be reimbursed by the Medical Assistance Administration (MAA), a hospice agency must be:

- Medicare, Title XVIII certified; and
- Enrolled with MAA as a provider of Hospice care.

All services provided through a hospice agency must be performed by qualified personnel as required through Medicare's certification process in effect as of February 1, 1999. For more information on Medicare certification, contact:

Department of Health
Hospice Certification Program
Mailstop 47852
Olympia, WA 98504-7852

Freestanding hospice agencies, licensed as hospitals by the Department of Health, must sign an additional contract with MAA to receive payment from MAA.

Client Eligibility

Who is eligible? (WAC 388-551-1200)

Medicaid clients who voluntarily choose hospice care are eligible if they:

- Are certified by a physician as terminally ill; **and**
- Have a Medical Assistance IDentification (MAID) card with one of the following identifiers:

  - ✓ **LCP-MNP** – (Limited Casualty Program – Medically Needy Program);
  - ✓ **Children's Health**; and
  - ✓ **CNP** – (Categorically Needy Program)
    (General Assistance – Disability Determination Pending [GA-X] clients are eligible for hospice services and will be identified by the CNP identifier on their MAID cards.)

Is the provider responsible for verifying the client's current medical eligibility?

YES! Providers are accountable for verification of a client's current medical eligibility, especially if there is doubt of coverage. The medical eligibility verification (MEV) service provides access to on-line MAA client eligibility data and can be purchased through MAA-approved MEV contractors.

The purchase of MEV services through the MAA contractors provides you with necessary MAA client eligibility information for billing purposes. The contracted companies are listed in your General Information Booklet (see the *Important Contacts* section). Please contact these companies directly.

What if the client is pending eligibility?

1. Call the client's Community Services Office (CSO) or Home and Community Services (HCS) office to confirm pending eligibility. (See Appendix A for lists.)
2. Inform the CSO or HCS office that the client is in need of hospice care.
3. Ask for priority handling of the client's care and a copy of their MAID card or an award letter as soon as the client is approved.
4. You must notify the MAA Hospice Coordinator within 5 working days of confirmation of the client's eligibility (see the *Important Contacts* section).

Who is not eligible?

Clients who present MAID cards with the following identifiers are **not eligible** for hospice services:

- **Family Planning Only**;
- **QMB – Medicare Only** (Qualified Medicare Beneficiary) (Receive fund for Medicare premium only);
- **GA-U No Out of State Care**;
- **Emergency hospital and ambulance only –** (Medically Indigent Program); and
- **Detox** (Alcoholism and Drug Addiction Treatment Support)

Are hospice services covered under managed care?

Hospice services are covered under managed care. Clients covered under managed care will have an HMO indicator in the HMO column on their MAID card. The managed care plan/provider must arrange or provide all services for a managed care client. The plan's 1-800 telephone number is located on the MAID card.

Coverage

What is included in core hospice services? (WAC 388-551-1210)

In the client's individual plan of care, the hospice interdisciplinary team identifies the specific hospice services to be provided to the client. Qualified staff must perform all hospice services. Nursing care, physician services, medical social services, and counseling are **core hospice services** and must be available and offered to the client on a routine basis.

Hospice services must be all of the following:

- ✓ Medically necessary for palliative care;
- ✓ Related to the client's terminal illness;
- ✓ Prescribed by the client's attending physician, alternate physician, or hospice medical director;
- ✓ Supplied or arranged for by the hospice provider; and
- ✓ Included in the client's plan of care.

What services are included in the hospice day rate?

The following intermittent services and supplies are **reimbursed by MAA's hospice day rate** and must be available from, and offered by, the hospice provider for the client as determined by the client's hospice interdisciplinary team:

- **Medical equipment and supplies** that are medically necessary for palliative care related to the client's terminal illness. Medical equipment and supplies must be prescribed by the client's attending physician and supplied, or arranged for, by the hospice agency.

- **Drugs and biologicals** used primarily for the relief of pain and management of symptoms related to the client's terminal illness. Drugs and biologicals must be prescribed by the client's attending physician and supplied, or arranged for, by the hospice agency.

  Note: Bill MAA separately for enteral parenteral supplies only when there is a pre-existing diagnosis requiring enteral/parenteral support. This pre-existing diagnosis must not be related to the diagnosis that qualifies the clients for hospice.

- **Home Health Aide services** furnished by qualified aides of the hospice agency. A registered nurse must complete a home-site supervisory visit every two weeks to assess aide services provided.

- **Physical therapy, occupational therapy, and speech-language therapy** provided through the hospice to manage symptoms or enable the client to safely perform ADLs (activities of daily living) and basic functional skills.

- **Physician services** related to administration of the plan of care for the terminal illness.

- **Nursing care** provided through the hospice agency by either:

  - ✓ A registered nurse; or
  - ✓ A licensed practical nurse under the supervision of a registered nurse.

- **Medical social services** provided through the hospice by a social worker under the direction of a physician.

- **Counseling services** provided through the hospice agency to the client and his or her family members or caregivers.

- **Medical transportation services** when:

  - ✓ approved by the hospice agency;
  - ✓ related to terminal illness; and
  - ✓ part of client's individual plan of care.

- **Short-term, inpatient care** provided in a Medicare-certified hospice inpatient unit, hospital, or nursing facility. Services provided in an inpatient setting must conform to the written plan of care and will be reimbursed through the hospice agency.

- **Homemaker services** arranged for by the hospice agency.

- **Outpatient hospital services,** including emergency room visits and all outpatient procedures.

- **Laboratory and radiology services,** technical component only.

- **Availability of clergy**. The hospice agency must allow clients the opportunity to visit with clergy and other members of religious organizations at their request.

Exceptions:

When Medicaid clients elect hospice care, they waive all rights to Medicaid payments for the following services:

⇒ Covered Medicaid hospice benefits and supplies received at the same time **from any other hospice agency**; and

⇒ Any covered Medicaid services and supplies from any other provider, related to the treatment of the terminal illness or a related condition, **except** services:

- Provided (either directly or arranged for) by the designated hospice;
- Provided by a consulting physician as arranged by the hospice;
- Provided by another hospice under arrangements made by the designated hospice; or
- Provided by the client's attending physician.

What services are not included in the hospice day rate?

The following services are not included in the hospice day rate.

- Dental care;
- Eyeglasses;
- Hearing aids;
- Podiatry;
- Chiropractic services;
- Ambulance transportation, if not related to client's terminal illness;
- Brokered transportation;
- Community Options Program Entry System (COPES) or Title XIX Personal Care Services, **if** the client is eligible for these services. Eligibility is determined by the local Aging and Adult Services Administration (AASA) field office and will be **reimbursed by AASA**;
- Medically Intensive Home Care Program (MIHCP) as determined by the Division of Developmentally Disabled (DDD) and reimbursed by Medicaid;
- Clients who are eligible for Coordinated Community Aids Services Alternative (CCASA) are not eligible for hospice coverage. CCASA clients' eligibility payments are determined by the Department of Health; and
- Services not related to the terminal condition.

If the above service(s) are covered under the client's Medicaid program, the provider of service must bill MAA separately using the applicable fee schedule.

Provider Requirements

How do clients choose hospice care? (WAC 388-551-1310)

A client chooses to receive hospice care through a series of time-limited periods, called election periods. Hospice providers must obtain physician certifications for each election period, and file them in the client's hospice record.

A client's hospice coverage must be available for two initial 90-day election periods followed by an unlimited number of succeeding 60-day election periods.

The client, or their representative, must sign the election statement provided by the hospice agency when they choose hospice care. This election statement must be kept in the client's hospice record.

The election statement must include the following:

- Name and address of the hospice that will provide the care;
- Proof that the client was fully informed about hospice care and waiver of other Medicaid services;
- Effective date of the election; **and**
- Signature of the client or client's representative.

The hospice agency must notify the MAA Hospice Coordinator of the start-of-care date within 5 working days of the first day of hospice services (this applies to eligible MAA clients only).

See the *Client Eligibility* section for clients who have chosen hospice care, but whose eligibility is **"pending."** Notify the MAA Hospice Coordinator only when an eligible MAA client chooses hospice care.

When do I notify MAA of a client's change in hospice status? (WAC 388-551-1400)

Notification within 5-working days avoids duplicative payments for services related to a client's terminal illness, and ensures MAA payment to the Hospice Provider. Hospice election and **any** changes in a client's hospice status must be **reported within 5-working days** to MAA **and** the client's **local** Community Services Office (CSO), or Home and Community Services office (HCS). The following list shows the typical process flow for Hospice Notification:

1. The client chooses the Hospice benefit.
2. The Hospice provider advises the local CSO/HCS staff that this client is new for Medicaid, or is changing Hospice status (*if client is on Medicaid, notify MAA at the same time as the CSO/HCS office*).
3. The local CSO/HCS staff determines eligibility and enters information into Automated Client Eligibility System (ACES) record.
4. The local CSO/HCS staff sends an award letter to the Hospice provider showing new Medicaid eligibility status.
5. The Hospice provider notifies MAA's Hospice Coordinator.
6. The MAA Hospice Coordinator enters information into the Medicaid Management Information System (MMIS). In order for MAA to make an entry into MMIS, the client's ACES record must show current eligibility for medical assistance, and the Hospice program.

If the local office, and MAA's Hospice Coordinator is not notified when a client revokes hospice care, the MAID card continues to stipulate that the client is only eligible for Hospice services, and not eligible for regular medical services. Hospice providers must **notify both** the MAA Hospice Coordinator and the staff in either the local CSO, or the local HCS office **within 5-working days** from when a client:

- Begins the first day of hospice care;
- Changes Hospice providers. Both the old and new Hospice provider must supply all of the following:

  - ✓ Name of the current Hospice providing care;
  - ✓ Name and provider number of the new Hospice provider;
  - ✓ Effective date of discharge from the old Hospice provider; and
  - ✓ Effective date of admit to the new Hospice provider.

- Revokes the Hospice benefit (home or institutional);
- Discharges from the Hospice benefit;
- Enters an institutional facility for other than Respite Care;
- Leaves an institutional facility as a resident; or
- Dies.

Failure to notify the appropriate DSHS administration could result in the client being denied medically necessary services, and the provider being denied payment. For EXAMPLE:
The client revokes hospice care. The hospice provider fails to notify MAA's Hospice Coordinator and local CSO/HCS office. The client and/or family attempt to get a prescription filled at the pharmacy. The pharmacist does not fill the prescription because the client is on hospice. The client or family is then forced to go without, or pay for the prescription. According to Washington Administrative Code (WAC), the pharmacy cannot legally force Medicaid clients to pay for their drugs when the drugs are a covered service.

Notify the HCS office for clients in nursing facilities, or clients eligible for the following long-term care programs: COPES, CHORE Services, or Medicaid Personal Care Services (*administered by AASA*).

Notify the CSO for all other clients.

A listing of the local CSO and HCS offices is attached for your convenience.

Notify the MAA Hospice Coordinator by **fax at 360-586-5299** ANYTIME there is a change in the client's Hospice election status. If you need clarification or have questions call the MAA Hospice Coordinator at **1-800-545-5392**. A sample fax sheet is attached if you'd like to use it to notify MAA of changes.

How does a hospice provider process an election certification? (WAC 388-551-1310)

The hospice provider must document the client's medical prognosis showing life expectancy of six months or less **if the terminal illness runs its normal course.**

The certification must meet all of the following criteria:

- For the **initial** election period, signatures of the hospice medical director and the client's attending physician; and
- For **subsequent** election periods, signature of the hospice medical director.

Verbal certifications for subsequent election periods by the hospice medical director or the client's attending physician must be documented in writing no later than two calendar days after hospice care is initiated or renewed.

☞ **NOTE:** The remaining days of the current election period are forfeit when a client:

- Discharges hospice;
- Leaves hospice without notice; or
- Revokes hospice.

The client may re-enter the next consecutive election period immediately upon re-certification. The client does not need to wait for the forfeit days to pass before the next consecutive election period begins.

Hospice Coordination of Care (WAC 388-551-1330)

- Once a client chooses hospice care from a hospice agency, that client gives up the right to:

  - ✓ Covered Medicaid hospice services and supplies received at the same time from any other hospice agency; and
  - ✓ Any covered Medicaid services and supplies related to the terminal illness from any other provider.

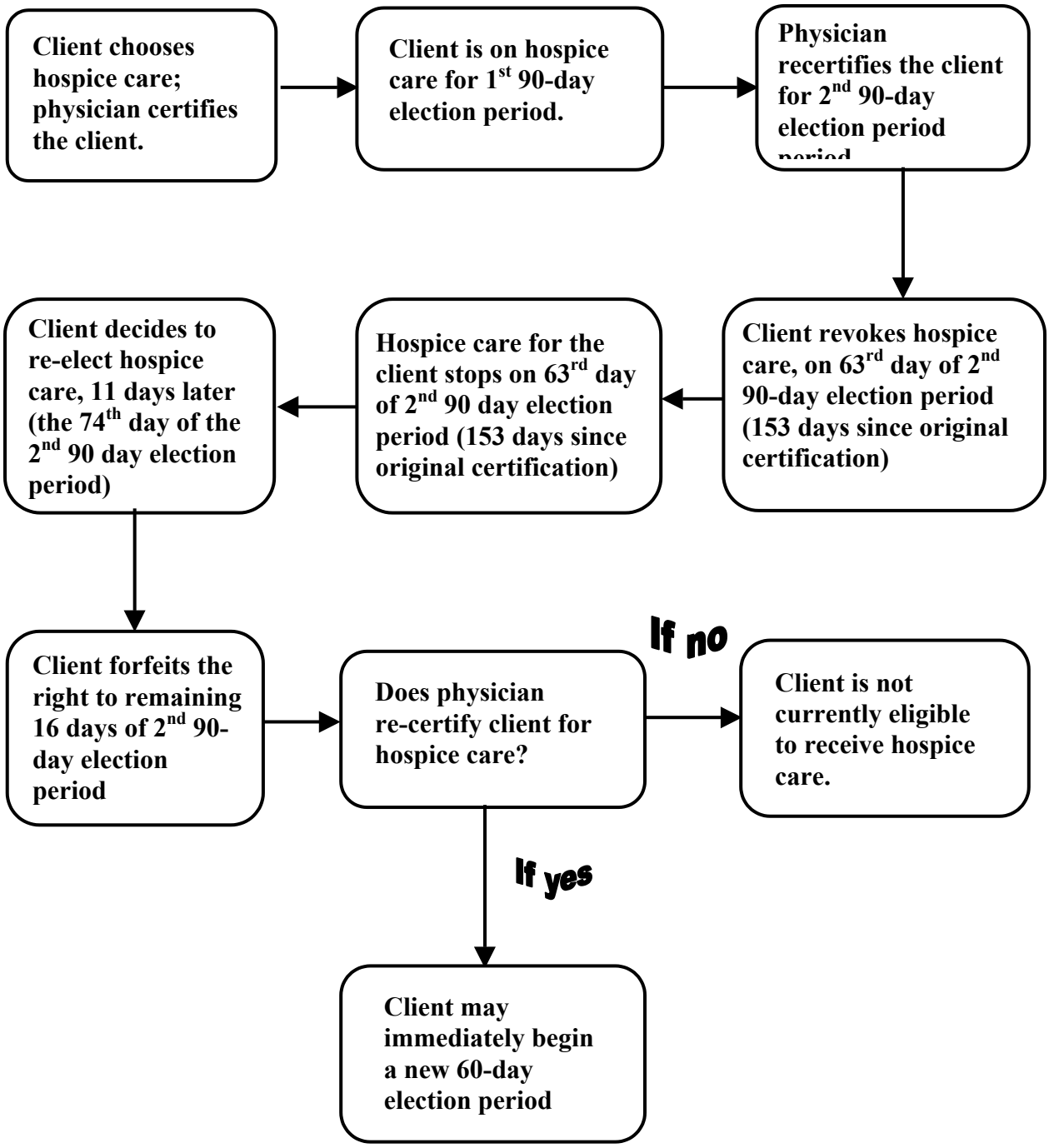
- Services and supplies not covered by the Medicaid hospice benefit are paid separately, if covered under the client's Medicaid eligibility. These services include, but are not limited to: COPES, MIHCP, and CCASA.

- The hospice provider must coordinate the client's medical management for the terminal illness.

- All of the client's providers, including the hospice provider, must coordinate:

  - ✓ The client's health care; and
  - ✓ Services available from other department programs, such as COPES.

How do hospice election periods work? (WAC 388-551-1315)



What are MAA's requirements for the hospice Plan of Care? (WAC 388-551-1320)

- In accordance with Medicare, the hospice interdisciplinary team must establish a client's hospice plan of care before delivering hospice services. Hospice services delivered must be consistent with that plan of care.

- A registered nurse or physician must conduct an initial assessment of the client and develop the plan of care with at least one other member of the hospice interdisciplinary team.

- The hospice interdisciplinary team must review in a case planning conference the plan of care no later than two working days after it is developed.

- The plan of care must be reviewed and updated every two weeks by at least three members of the hospice interdisciplinary team, including at least:

  - ✓ A registered nurse;
  - ✓ A social worker; and
  - ✓ One other hospice interdisciplinary team member.

What happens when…

…clients leave hospice care without notice? (WAC 388-551-1340)

When a client chooses to leave or refuses hospice care without giving the hospice provider a properly completed revocation statement, the hospice provider must do all of the following to be reimbursed:

- Notify MAA's Hospice Coordinator within **five working days** of becoming aware of the client's decision;
- Stop billing MAA for hospice payment (see WAC 388-551-1400 for further requirements);
- Notify the client, or the client's representative, that the client's discharge has been reported to MAA; and
- Document the effective date and details of the discharge in the client's hospice record.

The hospice agency must notify the MAA Hospice Coordinator within 5 working days of becoming aware of a client's decision to leave or refuse hospice care .

…clients discharge from hospice care? (WAC 388-551-1350)

Hospice provider may discharge a client from hospice care when the client:

- Is no longer certified for hospice care;
- Is no longer appropriate for hospice care; or
- Seeks treatment for the terminal illness from outside the plan of care as defined by the hospice interdisciplinary team.

…clients end (revoke) hospice care? (WAC 388-551-1360)

A client or family member may choose to end hospice care at any time by signing a revocation statement. After a client revokes hospice care, the client forfeits hospice services for any remaining days in that election period. The client does not have to wait for the forfeited days to pass before they may re-enter the next consecutive election period. The client may enter the next consecutive election period immediately.

The revocation statement documents the client's choice to stop Medicaid Hospice care. The revocation statement must be kept in the client's hospice record and include all of the following:

- Client or family member's signature;
- Date the revocation was signed; and
- Actual date that the client or family member chose to stop receiving hospice care.

The hospice agency must notify the MAA Hospice Coordinator within 5 working days after a client has revoked the hospice services (this applies to eligible MAA clients only).

…clients switch hospice providers? (WAC 388-551-1400)

A client may choose to change or transfer to a different hospice provider **one** time during each certification (election) period. In addition to the notification requirements, the current hospice provider must document all of the following:

- Name of the hospice that is providing the care;
- Name of the new hospice; and
- Effective date of the change.

Both hospice agencies must notify the MAA Hospice Coordinator of the transfer within 5 working days of the date the client makes the change (this applies to eligible MAA clients only).

…clients die? (WAC 388-551-1400)

The hospice agency must notify the MAA Hospice Coordinator within **5 working days** of the client's death.

Reimbursement

How does MAA determine what rate to pay? (WAC 388-551-1510)

Payment to hospice providers for services (not room and board) is a day rate calculated by one of the following methods and adjusted for current wages:

- Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence; or

- Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

Payments for room and board to free-standing hospice agencies licensed as hospitals are determined by using MAA's administrative statewide average day rate in effect at the time the contract is signed.

Payments for COPES services are made directly to the COPES provider.

- Patient participation in that case is paid separately to the COPES provider.
- Hospice providers must bill MAA directly for hospice services.

How does MAA reimburse for nursing facility residents?
(WAC 388-551-1510)

Eligible clients who reside in a nursing facility may elect to receive hospice services **excluding** nursing home inpatient respite care.

- The hospice agency and the nursing facility must have a written agreement that specifies their roles and responsibilities regarding the client's care.

- A room and board rate will be paid to the hospice provider in addition to the routine home care or continuous home care rate. The rate is based on 95% of the nursing facility's average Medicaid per diem rate as determined by the Aging and Adult Services Administration (AASA). **It is the hospice provider's responsibility to reimburse the nursing facility for room and board.**

- Once a nursing facility client elects Medicaid hospice, any payment being made directly to the nursing facility will be discontinued. The nursing facility must remove the client from the monthly Medicaid billings turnaround document (TAD).
- The client may be required to contribute toward the cost of the nursing facility room and board rate.

    - ✓ The HCS financial worker will determine whether the client must contribute and will send a copy of the client's award letter, including the amount the client must pay, to the hospice agency.

    - ✓ The hospice agency will collect the client's share of the nursing facility room and board and forward it to the nursing facility.

    - ✓ If the room and board amount is more than the client's share, the hospice agency will bill MAA the difference, and forward that amount to the nursing facility.

    - ✓ If the client in the nursing facility elects hospice during the month and the cost of the nursing facility, prior to hospice, is less than the client’s share, then the nursing facility refunds the remainder to the hospice agency.

    - ✓ If the client in the nursing facility revokes hospice during the month and the cost of room and board is less than the client’s share, then the hospice agency refunds the remainder to the nursing facility.

Does MAA reimburse for the following physician services…

…administrative and supervisory services?

Administrative and general supervisory activities performed by physicians are **included** in the hospice day rate. These physicians are either employees of the hospice or are working under arrangements made with the hospice agency. The physician serving as the medical director of the hospice and/or the physician member of the hospice interdisciplinary team would generally perform the following activities:

- Physician participation in the establishment of plans of care;
- The supervision of care and services;
- The periodic review and updating of plans of care; **and**
- The establishment of governing policies.

These activities cannot be billed separately.

…volunteer services?

Volunteer services are services provided to the hospice by the attending physician. MAA does not reimburse for these services. The attending physician must treat Medicaid clients the same as other patients in the hospice. Volunteer physician services provided to non-Medicaid clients must also be provided to Medicaid clients.

…professional services?

Who can bill?

MAA reimburses for professional services only when they are billed by one of the following:

- ✓ Primary Physician; or
- ✓ Hospice Agency (using Hospice Clinic # beginning with 7xxxxxx).

What provider number do I use?

Bill MAA for all professional services in one of the following ways:

1. When the primary physician performs the service, bill using their provider number. *Include the following information on the HCFA-1500 claim form:*

Field #	What do I need to put here?
33 – GRP#	Primary Physician's Provider Number

- OR -

2. When a physician, other than the primary physician, performs the service, bill using the hospice clinic number. *Include the following information on the HCFA-1500 claim form:*

Field #	What do I need to put here?
17 and 17a	Primary Physician Name & Provider Number
33 – PIN#	Performing Provider Number
33 – GRP#	Hospice Agency Clinic Provider Number

Radiology/laboratory services: When billing for the professional component, include **modifier 26** in field 24 D on the HCFA-1500 claim form, along with the appropriate procedure code. (See #1 or #2 above, as applicable.) Charges for the technical component of these services, such as lab and x-rays, are **included** in the hospice day rate.

Consulting physicians' services: Consulting physicians services must be arranged for, and billed by, the hospice agency. MAA will deny claims for these services if they are billed directly by the physician. (See #2 above.)

Hospice Revenue Codes

Enter the following revenue codes and service descriptions in the appropriate form locators.

Code #	Description of Code
651	**Routine Home Care** - The established rate is a capitated rate regardless of the volume or intensity of routine home care services provided on any given day.
652	**Continuous Home Care** - For every hour or part of an hour of continuous care, the hourly rate is reimbursed to the hospice up to 24 hours a day. Bill continuous care as a separate line entry on the UB-92 claim form for each day this level of care is provided.
653	**Nursing Facility Room and Board** - Enter the words **"Room and Board"** in form locator 43. Enter the nursing facility's name or provider number in form locator 83 or in the **Remarks** form locator.
655	**Inpatient Respite Care** 1) MAA will pay for respite care for a **maximum of five (5) consecutive days.** 2) MAA will deny the **entire claim** if the hospice agency bills for more than five (5) consecutive days of respite care. 3) Bill MAA for the sixth and subsequent days at the routine home care rate. 4) Itemize the individual days of inpatient respite care services on the **UB-92 claim form**. 5) **If the client dies during the five-day respite period, bill MAA the respite rate for the ending date of service.**
656	**General Inpatient Care** - Bill the day of discharge from the hospital at the routine home care rate. If the client dies in the hospital, bill MAA the general inpatient rate for the ending date of service.

Fee Schedule

Hospice Services Provided Inside Client's Home

Counties (Non-MSA & MSA Areas)	County Code	Routine Home Care (651)	Continuous Home Care Hourly (652)
W A S H I N G T O N			
Non-MSA Areas			
Adams, Asotin, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Garfield, Grant, Grays Harbor, Jefferson, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, San Juan, Skagit, Skamania, Stevens, Wahkiakum, Walla Walla, Whitman	**9950**	**$120.92**	**$29.40**
MSA Areas			
Benton (Kennewick-Richland)	**6740**	**$127.19**	**$30.93**
Clark (Vancouver)	**6440**	**$128.45**	**$31.23**
Franklin (Pasco)	**6740**	**$127.19**	**$30.93**
Island	**7600**	**$130.54**	**$31.74**
King, Snohomish (Seattle-Everett)	**7600**	**$130.54**	**$31.74**
Kitsap (Bremerton)	**1150**	**$125.50**	**$30.52**
Pierce (Tacoma)	**8200**	**$132.66**	**$32.26**
Spokane (Spokane)	**7840**	**$124.75**	**$30.34**
Thurston (Olympia)	**5910**	**$130.44**	**$31.72**
Whatcom (Bellingham)	**0806**	**$134.41**	**$32.69**
Yakima (Yakima)	**9260**	**$123.91**	**$30.13**

*** MSA = Metropolitan Statistical Area**

Hospice Services Provided Outside Client's Home

Non-MSA Areas & MSA Areas	Provider Name	Inpatient Respite (655)	General Inpatient Care (656)
W A S H I N G T O N			
Non-MSA Areas	Assured Home Health & Hospice	**$123.60**	**$535.85**
	Central Basin Home Health & Hospice	**$123.60**	**$535.85**
	Central Washington Hospital Hospice	**$123.60**	**$535.85**
	Community Home Health & Hospice	**$123.60**	**$535.85**
	Harbors Home Health Services	**$123.60**	**$535.85**
	Home Care of Kittitas Valley	**$123.60**	**$535.85**
	Hospice of the Gorge	**$123.60**	**$535.85**
	Okanogan Regional Hospice	**$123.60**	**$535.85**
	Tri-State Hospital Hospice	**$123.60**	**$535.85**
	Walla Walla Community Hospice	**$123.60**	**$535.85**
	Whitman Home Health & Hospice	**$123.60**	**$535.85**
MSA Areas (Counties)			
Benton (Kennewick-Richland)	Tri-Cities Chaplaincy	**$128.71**	**$561.83**
Clark (Vancouver)	Hospice Southwest	**$129.74**	**$567.06**
King, Snohomish (Seattle-Everett)	Community Health Service	**$131.44**	**$575.71**
	Evergreen Hospice & Home Health	**$131.44**	**$575.71**
	Highline Home Health & Hospice	**$131.44**	**$575.71**
	Hospice of Seattle	**$131.44**	**$575.71**
	Hospice of Snohomish County	**$131.44**	**$575.71**
	Swedish Home Health & Hospice	**$131.44**	**$575.71**
	Visiting Nurse Services of the NW	**$131.44**	**$575.71**

*** MSA = Metropolitan Statistical Area**

Hospice Services Provided Outside Client's Home (cont.)

Non-MSA Areas & MSA Areas	Provider Name	Inpatient Respite (655)	General Inpatient Care (656)
W A S H I N G T O N			
Kitsap (Bremerton)	Hospice of Kitsap County	**$127.34**	**$554.84**
Pierce (Tacoma)	Good Samaritan Hospice	**$133.18**	**$584.52**
	Multicare Hospice of Tacoma	**$133.18**	**$584.52**
	St. Joseph Hospital Hospice	**$133.18**	**$584.52**
Spokane (Spokane)	Hospice of Spokane	**$126.73**	**$551.75**
	Horizon Hospice	**$126.73**	**$551.75**
Thurston (Olympia)	Providence Sound Home Care	**$131.37**	**$575.32**
Whatcom (Bellingham)	Skagit Hospice	**$134.60**	**$591.78**
	Whatcom Hospice	**$134.60**	**$591.78**
Yakima (Yakima)	Hospice of Yakima	**$126.04**	**$548.23**
	Lower Valley Hospice	**$126.04**	**$548.23**
	Memorial Home Care Services	**$126.04**	**$548.23**
B O R D E R A R E A S			
Multnomah (OR)	Kaiser Permanente Hospice	**$129.74**	**$567.06**

*** MSA = Metropolitan Statistical Area**

Billing

How do I bill for general services? (WAC 388-551-1500)

All services related to a client's terminal illness are included in the hospice day rate through one of the following four levels of hospice care. MAA does not pay hospice providers for the client's last day, except for the day of death.

Bill MAA using your hospice 7-digit provider number beginning with 399. All claims for these services must be submitted on a UB-92 claim form (see How to Complete the UB-92 Claim Form).

- **Routine Care** for each day the client is at their residence, with no restriction on length or frequency of visits, dependent on the client's needs.

- **Continuous care** is acute episodic care received by the client to maintain the client at their home and addresses a brief period of medical crisis. Continuous care consists mainly of nursing care. This benefit is limited to:

  - ✓ A minimum of 8 hours of care provided during a 24-hour day. This care may be interrupted *(*for example, four hours in the morning and four hours in the evening is acceptable); **and**
  - ✓ Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care; **and**
  - ✓ Homemaker, home health aide, and attendant services that may be provided as supplements to the nursing care.

- **Inpatient Respite Care** is care received in an approved nursing facility or hospital to relieve the primary caregiver. This benefit is limited to:

  - ✓ No more than five consecutive days; and
  - ✓ A client not residing in a nursing facility.

- **General inpatient hospice care** is for pain and symptom management that cannot be done in other settings.

  This benefit is limited to brief periods of care delivered in MAA-approved:

  - ✓ Hospitals;
  - ✓ Nursing facilities; or
  - ✓ Hospice inpatient facilities.

  The services must conform to the client's written plan of care.

What is the time limit for billing?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days **after** you provide a service(s). Delivery of a service or product does not guarantee payment.

- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive[1] or Delayed[2] certification period.

- **MAA will not pay if:**

  - ✓ The service or product is not medically necessary;
  - ✓ The service or product is not covered by MAA;
  - ✓ The client has third party coverage and the third party pays as much as, or more than, MAA allows for the service or product; or
  - ✓ MAA is not billed within the time limit indicated above.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

[1] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

How do I bill for clients who are eligible for both Medicare and Medicaid? (WAC 388-551-1530)

If a client is eligible for both Medicare and Medicaid, you must first submit a claim to Medicare within its time limitations. MAA may make an additional payment after Medicare reimburses you.

All MAA hospice requirements and limitations are the same whether the client is eligible for:

- Medicare and Medicaid; or
- Medicaid only.

Medicare Part A

Medicare Part A covers hospice care in full.

Medicare/Medicaid clients in nursing facilities

The nursing facility and the hospice provider must comply with the conditions of participation as noted in the *Reimbursement* section under Hospice clients who are nursing facility residents.

Hospice providers must bill:

- Medicare for hospice services provided to Medicare/Medicaid clients; and
- Medicaid for nursing facility room and board using the UB-92 claim form.

The client may be required to contribute toward the cost of the nursing facility room and board rate. (See the explanation under the *Reimbursement* section.)

Medicare Part B/Professional Services

The hospice agency may bill MAA for services to clients who are *only* eligible for Medicare Part B. The hospice agency must indicate that the client has Medicare Part B coverage only in *field 19* on the HCFA-1500 crossover claim form.

QMB (Qualified Medicare Beneficiaries Program Limitations):

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

If the client has a CNP or MNP MAID card in addition to the QMB MAID card, and the service you provide is covered by Medicare **and** Medicaid, MAA will pay the lesser of

- The full coinsurance and deductible amounts due, based upon the Medicare allowed amount, or
- The department's maximum allowable fee for that service minus the amount paid by Medicare.

QMB-MEDICARE Only (Qualified Medicare Beneficiaries):

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA pays the deductible and/or coinsurance up to Medicaid's allowed amount.

- If Medicare and ***not*** Medicaid covers the service, MAA pays the deductible and/or coinsurance up to Medicare's allowed amount.

- If the service is not covered or is denied by Medicare, MAA **does not** reimburse.

After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov, or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records does MAA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service must be in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Quantity of medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

Notifying Clients of Their Rights (Advanced Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How to Complete the UB-92 Claim Form

The numbered boxes on the UB-92 are called **form locators**. Only form locators that pertain to MAA are addressed here. If you are billing electronically, use claim type **"M" - Outpatient**.

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with MAA Division of Program Support (DPS).

3. **Patient Control Number** - Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

4. **Type of Bill** - Enter **811**.

6. **Statement Covers Period** – Enter the beginning and ending dates of the service(s) covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on his/her Medical Assistance IDentification (MAID) card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** – Enter the client's birthdate.

17. **Admission Date** - Enter the first date of service for the billing period (MMDDYY).

42. **Revenue Code** - Enter the appropriate revenue code(s) as listed in the *Hospice Revenue Codes and Billing Information* Section. Enter *001* for total charges on line 23 of this form locator on the final page.

43. **Description** –

- Enter a narrative description of services performed.
- Enter the date on which the related service was given.
- Enter the description *total charges* on line 23 of this form locator on the final page.

46. **Units of Service** - Enter the number of days of service. Make sure the units match the beginning and ending service dates on your claim. If they do not match, your claim will be denied.

47. **Total Charges** - Enter the charge for each line. After all line charges, enter the total of all charges. Enter the total of this column as the last detail on line 23 of this form locator on the last page.

50. **Payer Identification: A/B/C -**

Enter name of insurer(s).

51. **Medicaid Provider Number** – Enter the provider number issued to you by DPS. This is the seven-digit provider number that appears on your Remittance and Status Report.

54. **Prior Payments: A/B/C** – Enter the amount due or received from other insurance. **Due from other insurance or patient spend-down** – Enter any amount due from the client here.

55. **Estimated Amount Due: A/B/C** – Total charges *minus* any amount(s) entered in form locator *54*.

58. **Insured's Name: A/B/C** – If other insurance benefits are available and coverage is under another name, enter the *insured's* name here.

59. **Patient's Relationship To Insured A/B/C** - Enter one of the following two-digit codes indicating the relationship of the client to the identified insured:

01 = Patient is insured
02 = Spouse
03 = Natural child/insured has financial responsibility
04 = Natural child/insured does not have financial responsibility
05 = Step child
06 = Foster child
07 = Ward of court/patient ward of insured
08 = Employee/patient employed by insured
09 = Unknown
10 = Handicapped dependent
11 = Organ donor
12 = Cadaver donor
13 = Grandchild
14 = Niece/nephew
15 = Injured plaintiff/patient claiming insurance as result of injury covered by insured
16 = Sponsored dependent
17 = Minor dependent of minor dependent
18 = Parent
19 = Grandparent

60. **Cert-SSN-HIC-ID No.** – Enter the Medicaid Patient (client) Identification Code (PIC) – an alphanumeric code assigned to each Medical Assistance client – exactly as shown on the MAID card. This information is obtained from the client's current MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

61. **Insurance Group Name A/B/C** – If other insurance benefits are available, enter the *name of the insurance group or plan* under which the insured is covered.

62. **Insurance Group Number A/B/C** - If other insurance benefits are available, enter any identification number identifying the *group* through which the individual is insured.

65. **Employer Name A/B/C** – If other insurance benefits are available through employment, enter the employer's name.

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the client's principal diagnosis.

68-75. **Other Diagnosis Codes** - Enter any ICD-9-CM diagnosis codes indicating conditions **other than** the principal condition.

82. **Attending Physician ID A/B** - Enter the seven-digit provider identification number.

83. **Other Physician** - When billing a nursing facility room and board rate, enter the nursing facility's seven-digit provider number.

84. **Remarks** - Enter any other pertinent information applicable to this claim that has not been entered in other form locators.

If billing **electronically**, enter in the **Remarks** field:

- The Medical Assistance provider number of the nursing facility and the letters **R/B** (Room and Board) in UPPER CASE.
- The length-of-stay in the nursing facility for the billing period. This length of stay should be in the form of dates (e.g., 05/01/99 to 05/31/99).
- Enter the provider number or the name of the nursing facility in which the client resides.

Sample UB-92 Claim Form:
Hospice Care

Sample UB-92 Claim Form:
Nursing Facility Room & Board

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be entered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the MAID card. This number consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17a. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.

19. When applicable. If the client has no Part A coverage, enter the statement "Client has Medicare Part B coverage only" in this field.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the claim number listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., May 04, 1999 = 050499).

24B. **Place of Service**: Required. These are the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
1	Inpatient hospital
2	Outpatient hospital office or ambulatory surgery center
3	Client's Residence
4	Emergency room
6	Congregate care facility
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Other

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Number.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: This is the seven-digit number assigned to you by MAA for:

A) An individual practitioner (solo practice); **or**

B) An identification number for individuals only when they are part of a group practice (see below).

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

Sample HCFA-1500 Claim Form: Hospice-Consulting Physicians

(Not available on website… please see hard copy.)

Sample HCFA-1500 Claim Form: Professional Component

(Not available on website… please see hard copy.)

How to Complete the Medicare Part B/Medicaid Crossover HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. The numbered boxes on the claim form are referred to as ***fields***. A number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. Use the instructions below to complete the HCFA-1500 form for crossover claims.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be entered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the HCFA-1500 claim form.
- Attach a complete, legible Medicare EOMB or the claim will be denied.

FIELD DESCRIPTION

1A. **Insured's I.D. No.**: Required. Enter the Medicaid Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification card. This information is obtained from the client's current monthly Medical Assistance IDentification card consisting of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tie breaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

NOTE: The MAID card is your proof of eligibility.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client. **Sex**: Check **M** (male) or **F** (female).

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

10. **Is Patient's Condition Related To**:

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*.

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. [The ICN number is the claim number listed on the Remittance and Status Report (RA).] Also enter the three-digit denial Explanation of Benefits (EOB) from the RA.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., May 4, 1999 = 050499).

24B. **Place of Service**: Required. Enter a **9**.

24C. **Type of Service**: Required. Enter a **9**.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter appropriate code and Coinsurance.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: Required. Enter **1**.

24K. **Reserved for Local Use**: Required. Enter Medicare payment per item.

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Number.

27. **Accept Assignment**: **Required**. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Enter the supplier's *Name, Address,* and *Phone #* on all claim forms. Enter your seven-digit provider number here.

Sample Medicare Part B/Medicaid Crossover
HCFA-1500 Claim Form

(Not available on website…
please see hard copy.)

Appendix A

COMMUNITY SERVICES DIVISION DIVISION March 3, 1999
HEADQUARTERS, REGIONAL & CSO DIRECTORY
50 CSOs - 12 Branch Offices - 3 Outstation's

NAMES - ADDRESSES	MAIL STOP	PHONE # & FAX
GRANT/ADAMS CSO (MOSES LAKE) 1620 South Pioneer Way Moses Lake, WA 98837	**B 13-2**	509-764-5600 Main 764-5747 Fax
OTHELLO CSO 1025 South First Street P.O. Box 711 Othello, WA 99344	**B 01-2**	509-488-9673 Main 488-5068 Fax
OKANOGAN CSO 130 South Main P.O. Box 3729 Omak, WA 98841	**B 24-1**	509-826-7200 Main 826-7293 Fax
SPOKANE CENTRAL CSO 1313 N. Maple St. Spokane, WA 99201	**B 32-3**	509-456-4404 Main 456-2461 Fax
COLFAX BRANCH OFFICE 418 South Main Suite 1 Colfax, WA 99111	**B 38-1**	509-397-4326 Main 397-3498 Fax
SPOKANE EAST CSO 121 South Arthur, PO Box 2640 Spokane, WA 99202-2640	**B 58-1**	509-533-2326 Main 533-2343 Fax
SPOKANE NORTH CSO 1925 East Francis Spokane, WA 99207-3747	**B 59-1**	509-483-5696 Main 483-5716 Fax

SPOKANE SOUTHWEST CSO 1313 North Maple Spokane, WA 99201-2749	**B 60-1**	509-458-2191 Main 456-3093 Fax
DAVENPORT BRANCH OFFICE 506 8th Street; P.O. Box 640 Davenport, WA 99122	**B 22-1**	509-725-5501 Main 725-2056 Fax
TRI-COUNTY/COLVILLE CSO 1100 South Main Colville, WA 99114	**B 33-1**	509-685-5600 Main 685-5606 Fax
NEWPORT BRANCH OFFICE 1600 West 1st St. P.O. Box 570 Newport, WA 99156-0570	**B 26-1**	447-4732 Fax
REPUBLIC OUTSTATION 147 North Clark Avenue P.O. Box 1037 Republic, WA 99166	**B 10-1**	775-2401 Fax
WENATCHEE CSO 805 South Mission P.O. Box 3088 Wenatchee, WA 98807	**B 4-1**	509-662-0511 Main 664-6340 Fax
CLARKSTON CSO 525 Fifth Street Clarkston, WA 99403	**B 2-1**	509-758-5537 Main 758-4582 Fax
GRANDVIEW CSO 1313 W. Wine Country Road P.O. Box 70 Grandview, WA 98930-0070	**B 70-1**	509-882-9300 Main 882-4589 Fax

KENNEWICK CSO 1020 North Edison Avenue P.O. Box 6330 Kennewick, WA 99336	**B 03-4**	509-735-7119 Main 736-2857 Fax
PASCO CSO 800 West Court P.O. Box 931 Pasco, WA 99301	**B 11-1**	509-545-1400 Main 546-2414 Fax
SUNNYSIDE CSO 810 East Custer Avenue P.O. Box 818 Sunnyside, WA 98944	**B 54-1**	509-839-7200 Main 839-7224 Fax
TOPPENISH CSO 306 Bolin Drive P.O. Box 470 Toppenish, WA 98948	**B 50-1**	509-865-2805 Main 865-1133 Fax
WALLA WALLA CSO 416 East Main P.O. Box 517 Walla Walla, WA 99362	**B 36-1**	509-529-0406 Main 522-4330 Fax
WAPATO CSO 102 North Wapato Avenue P.O. Box 66 Wapato, WA 98951	**B 75-1**	509-877-8122 Main 877-8149 Fax
YAKIMA CSO 1002 North 16th Avenue P.O. Box 12500 Yakima, WA 98909	**B 39-1**	509-575-2000 Main 454-4332 Fax
YAKIMA/KITTITAS CSO 1002 North 16th Avenue P.O. Box 12500 Yakima, WA 98909	**B 69-1**	509-454-4377 Main 575-2088 Fax

ELLENSBURG BRANCH OFFICE 521 Mountain View P.O. Box 366 Ellensburg, WA 98926	**B 19-1**	509-962-7710 Main 962-7736 Fax
ALDERWOOD CSO 19000 33rd Avenue West P. O. Box 97012 Lynnwood, WA 98046-9712	**N 52-1**	425-775-5555 Main 672-2295 Fax
BELLINGHAM CSO 4101 Meridian Street; PO Box 9706 Bellingham, WA 98227-9706	**B 37-1**	360-714-4000 Main Fin. * 714-4066 Fax
EVERETT CSO 840 North Broadway, Suite 200 Everett, WA 98201-1297	**N 31-1**	425-339-4000 Main 339-4890 Fax
MOUNT VERNON CSO 900 East College Way; Suite 100 Mount Vernon, WA 98273-5682	**B 29-1**	360-416-7444 Main Gen. 416-7279 Fax
FRIDAY HARBOR OUTSTATION 55 Second Street, Suite 101 P.O. Box 1215 Friday Harbor, WA 98250	**B 29-10**	378-4098 Fax
OAK HARBOR CSO 656 SE. Bayshore Drive #1 Oak Harbor, WA 98277	**B 15-1**	679-3524 Fax
SKYKOMISH VALLEY CSO 19705 SR 2 P.O. Box 7000 Monroe, WA 98272	**B 68-1**	360-794-1350 Main 794-1360 Fax

SMOKEY POINT CSO 3704 172nd Street NE, Suite P P.O. Box 3099 Arlington, WA 98223-3099	**B 65-1**	360-658-2200 Main 658-2294 Fax
BALLARD CSO 907 Northwest Ballard Way Seattle, WA 98107-4683	**N 42-1**	206-789-5200 Main 706-4252 Fax
BELLTOWN CSO 2106 - 2nd Avenue Seattle, WA 98121-2298	**N 47-1**	206-956-3353 Main 956-3360 Fax
BURIEN CSO 15811 Ambaum Boulevard Southwest Seattle, WA 98166-3090	**N 44-1**	206-439-5300 Main 439-5324 Fax
CAPITOL HILL CSO 1700 East Cherry Seattle, WA 98122-4694	**N 46-1**	206-568-5510 Main 720-3189 Fax
FEDERAL WAY CSO 1617 South 324th P.O. Box 4629 Federal Way, WA 98063-4629	**N 45-1**	253-661-4900 Main Fin. 661-4904 Fax
KING EASTSIDE CSO 14360 SE. Eastgate Way Bellevue, WA 98008-0429	**N 40-1**	425-649-4000 Main 649-4058 Fax
KING SOUTH CSO 25316 74th Avenue South P.O. Box 848 Kent, WA 98032-0848	**N 43-1**	253-872-2145 Main 872-2735 Fax

LAKE CITY CSO 11536 Lake City Way Northeast Seattle, WA 98125-5395	**N 74-1**	206-368-7200 Main 368-7189 Fax
RAINIER CSO 3600 South Graham Seattle, WA 98118-3034	**N 41-1**	206-760-2000 Main 760-2345 Fax
HOLGATE-RENTON CSO 1737 Airport Way South, Suite 100 P.O. Box 94107 Seattle, WA 98124-6407	**N 80-1**	206-626-5900 Main 626-5925 Fax
WEST SEATTLE CSO 4045 Delridge Way SW, Suite #300 Seattle, WA 98106	**N 55-1**	206-933-3300 Main 933-3315 Fax
BREMERTON CSO 4710 Kean Street Bremerton, WA 98312-3300	**W 18-1**	360-478-4995 Main 478-6960 Fax
PIERCE NORTH CSO 1949 South State Street, 2nd Floor Tacoma, WA 98405-9945	**N 49-1**	253-593-2950 Main 597-4319 Fax
PIERCE SOUTH CSO 1301 East 72nd Tacoma, WA 98404-3348	**N 48-1**	253-471-4400 Main 471-4411 Fax
PIERCE WEST CSO 1949 South State Street, 1st Floor Tacoma, WA 98405-9943	**N 67-1**	253-593-2760 Main 593-2313 Fax

PUYALLUP VALLEY CSO 1004 East Main Puyallup, WA 98372-9987	**N 51-1**	253-840-4600 Main 840-4715 Fax
ABERDEEN CSO 415 West Wishkah P.O. Box 189 Aberdeen, WA 98520	**W 14-1**	360-537-2600 Main 533-9445 Fax
ELMA BRANCH OFFICE 575 East Main, Suite A P.O. Box 799 Elma, WA 98541	**W 61-1**	360-482-8900 Main 482-2850 Fax
SOUTH BEND BRANCH OFFICE 725 West Robert Bush Drive P.O. Box 87 South Bend, WA 98586	**W 25-1**	360-875-6501 Main 875-0590 Fax
LONG BEACH BRANCH OFFICE 603 South Oregon P.O. Box 429 Long Beach, WA 98631	**B 71-1**	360-642-3791 Main 642-6229 Fax
CHEHALIS CSO 2025 Northeast Kresky Road P.O. Box 359 Chehalis, WA 98532	**S 21-1**	360-740-3800 Main 748-2286 Fax
KELSO CSO 711 Vine P.O. Box 330 Kelso, WA 98626-0026	**S 8-1**	360-577-2001 Main 577-2296 Fax
OLYMPIA CSO 5000 Capitol Boulevard P.O. Box 1908 Olympia, WA 98507-1908	**45455**	360-753-5983 Main 586-6787 Fax

ORCHARDS CSO 11900 Northeast 95th Street, Building 4 P.O. Box 4485 Vancouver, WA 98662	**S 53-1**	360-260-6400 Main 260-6423 Fax
GOLDENDALE BRANCH OFFICE 808 South Columbus P.O. Box 185 Goldendale, WA 98620	**B 62-1**	773-4282 Fax
STEVENSON BRANCH OFFICE 266 SW Second Street P.O. Box 817 Stevenson, WA 98648	**B 30-1**	509-427-5611 Main 427-4604 Fax
WHITE SALMON BRANCH OFFICE 221 North Main P.O. Box 129 White Salmon, WA 98672	**B 20-1**	493-1882 Fax
PORT ANGELES CSO 1020 East Front Street P.O. Box 2259 Port Angeles, WA 98362-0292	**B 5-1**	360-452-3381 Main 417-1461 Fax
NEAH BAY OUTSTATION Bayview Avenue, Community Building P.O. Box 153 Neah Bay, WA 98357	**B 64-2**	645-2452 Fax
PORT TOWNSEND BRANCH OFFICE 623 Sheridan P.O. Box 554 Port Townsend, WA 98368	**B 16-1**	379-5017 Fax
FORKS BRANCH OFFICE 421 5th Avenue Southwest Forks, WA 98331	**B 64-1**	374-5464 Fax

SHELTON CSO 2505 Olympic Hwyn, Suite 440 P.O. Box 1127 Shelton, WA 98584-0937	**W 23-1**	360-432-2000 Main 427-2010 Fax
VANCOUVER CSO 907 Harney Street P.O. Box 751 Vancouver, WA 98666	**S 6-1**	360-993-7700 Main 696-6406 Fax

April 1999

HOME & COMMUNITY SERVICES DIVISION HEADQUARTERS, REGIONAL & HCS DIRECTORY OFFICES WITH *FINANCIAL* STAFF				
NAMES - ADDRESSES	**HCS #**	**MAIL STOP/ COUNTY**	**PHONE**	**FAX**
HEADQUARTERS **Kathy Leitch, Director** **Tom Williams, Deputy Director** Home & Community Services Division (HCS) 600 Woodland Square Loop S.E. Lacey, WA 98503		45600	(360) 493-2542 (360) 493-9251	(360) 438-8633
REGION 1 1427 West Gardner Spokane, WA 99201-1935 **Pao Vue, Regional Administrator**		B 32-27	(509) 323-9400 1-800-459-0421	(509) 458-3558
Spokane HCS 1427 West Gardner Spokane, WA 99201-1935	57	B 32-27 Spokane Co.	(509) 323-9400 1-800-459-0421	(509) 458-3558
Colville HCS 1100 S. Main Colville, WA 99114-9545	78	B 33-5 Stevens Co.	(509) 685-5644 1-800-459-0421	(509) 684-7430
Moses Lake HCS 1620 So Pioneer Way Moses Lake, WA 98837-0301	81	B 13-4 Grant Co.	(509) 764-5657 1-800-671-8902	(509) 764-5656
Omak (Okanogan) HCS 130 S. Main Omak, WA 98841-3729	77	B 24-3 Okanogan Co.	(509) 826-7232 1-800-459-0421	(509) 826-7439
Wenatchee HCS 805 South Mission Wenatchee, WA 98801-3053	79	B 4-4 Douglas Co.	(509) 662-0559 1-800-670-8874	(509) 665-3312
REGION 2 P.O. Box 9817 (98909-9817) 1002 N 16th Avenue Yakima, WA 98902 **Melinda Lorenz, Regional Administrator**		B 39-14	(509) 575-2006 1-800-822-2097	(509) 575-2286

Yakima HCS P.O. Box 9817 (98909-9817) 1002 N 16th Avenue Yakima, WA 98902	82	B 39-14 Yakima Co.	(509) 575-2006 1-800-822-2097	(509) 575-2286
*** Ellensburg-Yakima HCS Branch Office** P.O. Box 366 521 E. Mountain View Ellensburg, WA 98926-0366	82*	B 19-3 Kittitas Co.	(509) 962-7760 1-800-310-4999	(509) 962-7736
Sunnyside HCS P.O. Box 818 2010 Yakima Valley Hwy/K15 Sunnyside, WA 98944-0818	83	B 54-4 Yakima Co.	(509) 839-7278 1-800-310-5923	(509) 839-6990
***Toppenish-Sunnyside HCS Branch Office** P.O. Box 470 (98948-0470) 306 Bolin Drive Toppenish, WA 98948-1644	83*	B 50-3 Yakima Co.	(509) 865-1127	(509) 865-2028
Pasco HCS P.O. Box 931 800 W Court Pasco, WA 99301-0931	84	B 11-7 Franklin Co.	(509) 545-2625 1-800-310-4833	(509) 545-2617
Walla Walla HCS 206 West Poplar Walla Walla, WA 99362-0219	85	B 36-4 Walla Walla Co.	(509) 527-4614 1-800-310-5678	(509) 527-4142
Clarkston HCS 525 Fifth Street Clarkston, WA 99403-2090	86	B 2-4 Asotin Co.	(509) 758-4562 (509) 758-4516 1-800-310-4881	(509) 758-4593
REGION 3 900 East College Way Suite 210 Mt. Vernon, WA 98273-5688 **Terry Marker, Regional Administrator**		B 29-3	(360) 416-7289 1-800-487-0416	(360) 416-7401
Mt. Vernon HCS 900 East College Way Suite 210 Mt. Vernon, WA 98273-5688	63	B 29-3 Skagit Co.	(360) 416-7289 1-800-487-0416	(360) 416-7401
Alderwood HCS 19009 33rd Avenue West, Suite 306 Lynnwood, WA 98036-4710	89	N 52-3 Snohomish Co.	(425) 672-2855 1-800-780-7089	(425) 672-3178

Bellingham HCS 600 Lakeway Drive Bellingham, WA 98225-5236	87	B 37-8 Whatcom Co.	(360) 738-6200 1-800-239-8292	(360) 676-2239
Everett HCS 840 N. Broadway, Suite 330 Everett, WA 98201-1262	92	N 31-8 Snohomish Co.	(425) 339-4010 1-800-780-7094	(425) 339-1885
Skykomish Valley HCS P.O. Box 7000 19705 SR #2 (no street delivery) Monroe, WA 98272-9902	90	B 68-3 Snohomish Co.	(360) 805-8895 1-800-398-4172	(360) 805-8569
Smokey Point HCS P.O. Box 3504 3310 Smokey Point Drive Arlington, WA 98223-3504	91	B 65-3 Snohomish Co.	(360) 653-0584 1-800-827-2984	(360) 653-0569
REGION 4 P.O. Box 24847 1737 Airport Way S., Suite 130 Seattle, WA 98124-0847 **Greg Heartburg, Regional Administrator**		N 95-2	(206) 341-7750 1-800-346-9257	(206) 464-6991
Holgate HCS P.O. Box 24847 Seattle, WA 98124-0847 1737 Airport Way S Suite 130 Seattle, WA 98124-6407	56	N 95-2 King Co.	(206) 587-4440 1-800-346-9257	(206) 464-6689
REGION 5 1949 South State Street Tacoma, WA 98405-2850 **Rick Bacon, Regional Administrator**		N 66-2	(253) 597-3600 1-800-442-5129	(253) 597-4296
Tacoma HCS 1949 South State Street Tacoma, WA 98405-2850	66	N 66-2 Pierce Co.	(253) 597-3600 1-800-442-5129	(253) 597-4296
Bremerton HCS 4710 Kean Street Bremerton, WA 98312-4397	88	W 18-7 Kitsap Co.	(360) 478-4990 1-800-422-7114	(360) 478-6467
***Puyallup HCS - Tacoma HCS Branch** 1011 E. Main Street, Suite 101 Puyallup, WA 98362	66*	N 51-2 Pierce Co.	(253) 840-4550 1-800-804-1327	(253) 840-4726

REGION 6 P.O. Box 45610 (98504-5610) 6737 Capitol Blvd. S., 1st Floor Tumwater, WA 98501 **Penny Black, Regional Administrator**		45610	(360) 664-7575 1-800-462-4957	(360) 664-7603
Tumwater HCS P.O. Box 45610 (98504-5610) 6737 Capitol Blvd. S., 1st Floor Tumwater, WA 98501	96	45610 Thurston Co.	(360) 664-7575 1-800-462-4957	(360) 664-7603
Aberdeen HCS P.O. Box 85 503 West Heron St. Aberdeen, WA 98520	94	W 14-5 Grays Harbor Co.	(360) 533-9218 1-800-487-0119	(360) 533-9729
Chehalis HCS P.O. Box 1186 500 SE Washington Ave., 3rd Flr. Chehalis, WA 98532	95	S 21-4 Lewis Co.	(360) 740-6572 1-800-487-0360	(360) 740-6585
Kelso HCS 711 Vine Street Kelso, WA 98626-2621	97	S 8-7 Cowlitz Co.	(360) 577-5424 1-800-605-7322	(360) 578-4106
Port Angeles HCS P.O. Box 2289 228 West 1st Street, Suite 0 Port Angeles, WA 98362	93	B 5-3 Clallam Co.	(360) 417-1423 1-800-280-9891	(360) 417-1416
Vancouver HCS 5411 E Mill Plain Blvd., Suite 25 Vancouver, WA 98661-7046	98	S 53-4 Clark Co.	(360) 992-7945 1-800-280-0586	(360) 992-7949
*** HCS branch offices share the same HCS office number.**				
HCS offices not co-located with CSOs:	**Spokane, Walla Walla, Alderwood, Bellingham, Smokey Point, Holgate, Puyallup, Tumwater, Vancouver, Pt. Angeles, Aberdeen, Chehalis**			

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Appendix B

DIAGNOSES THAT REQUIRE AN ASSESSMENT

Hospice staff must submit an assessment to the MAA Hospice Coordinator for clients admitted to hospice with one or more of the following diagnoses, including but not limited to:

Acute GI Bleed

Alzheimer's or Alzheimer's End Stage

Blindness

Cardiac Disease

CAD without End Stage

Cerebral Palsy without End Stage

CHF (Congestive Heart Failure) without End Stage

CVA (Cardiovascular Accident), or CVA End Stage

TIA (Transient Ischemic Attack), or TIA End Stage

Dementia or Dementia End Stage

Down's Syndrome without End Stage

FTT (Failure to Thrive)

IDDM (Diabetes), or IDDM End Stage

Kidney Disease/Failure without End Stage

Lack of Normal Physical Development

Liver Disease without End Stage

Malnutrition

MD (Muscular Dystrophy) without End Stage

MI (Myocardial Infarction) without End Stage

MS (Multiple Sclerosis) without End Stage

Multi-system failure

Parkinson's without End Stage

Peripheral Vascular Disease

Pneumonia

Pulmonary Fibrosis

Respiratory Failure

SIDS (Sudden Infant Death Syndrome)

Debility Unspecified.

This list will be modified by MAA as needed.

Hospice Notification Form

(Separate file)